By: Schwertner S.B. No. 760

A BILL TO BE ENTITLED

AN ACT

relating to provider access 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, 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;

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

(6) procedures for recipient outreach and education;

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

(A) not later than:

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

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

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

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

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims described by Subdivision (7)(A)(ii) on average not later than the 21st day after the date the claim is received by the organization;

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

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

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

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

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

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

(A) use advanced practice registered nurses and physician assistants in addition to physicians as primary care

providers to increase the availability of primary care providers in the organization's provider network; and

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

(i) selection and assignment as primary care providers;

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

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

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

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

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

(B) the contracting with physicians who are not network providers and who are of the same or related specialty as

the appealing physician to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal;

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

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

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

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

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

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

(20) a requirement that the managed care organization:

(A) develop and submit to the commission, before

the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network complies with the commission's provider access standards established under Section 533.0061 [~~will provide recipients sufficient access to:~~

[~~(i) preventive care;~~

[~~(ii) primary care;~~

[~~(iii) specialty care;~~

[~~(iv) after-hours urgent care;~~

[~~(v) chronic care;~~

[~~(vi) long-term services and supports;~~

[~~(vii) nursing services; and~~

[~~(viii) therapy services, including services provided in a clinical setting or in a home or community-based setting~~]; [~~and~~]

(B) continue to comply with the commission's provider access standards established under Section 533.0061 as a condition of contract retention and renewal;

(C) pay liquidated damages in the amount of $10,000 for each failure, as determined by the commission, to comply with an access standard established under Section 533.0061; and

(D) regularly, as determined by the commission, submit to the commission and make available to the public a report containing data on the sufficiency of the organization's provider network with regard to providing the care and services described under Section 533.0061(a) [~~Paragraph (A)~~] and specific data with

respect to access to specialty care, long-term services and supports, nursing services, and therapy services [~~Paragraphs (A)(iii), (vi), (vii), and (viii)~~] on the average length of time between:

(i) the date a provider makes a referral for the care or service and the date the organization approves or denies the referral; and

(ii) the date the organization approves a referral for the care or service and the date the care or service is initiated;

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

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

(B) the organization's provider network includes:

(i) a sufficient number of primary care providers;

(ii) a sufficient variety of provider types;

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

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

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

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

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

(B) focuses on measuring outcomes; and

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

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

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

(B) that adheres to the applicable preferred drug

list adopted by the commission under Section 531.072;

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

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

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

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

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

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

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

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

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

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

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

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

(K) under which the managed care organization or pharmacy benefit manager, as applicable:

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

(a) the drug is listed as "A" or "B" rated in the most recent version of the United States Food and Drug Administration's Approved Drug Products with Therapeutic

Equivalence Evaluations, also known as the Orange Book, has an "NR" or "NA" rating or a similar rating by a nationally recognized reference; and

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

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

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

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

(v) must establish a process for eliminating products from the maximum allowable cost list or modifying maximum allowable cost prices in a timely manner to remain consistent with pricing changes and product availability in the marketplace;

(vi) must:

(a) provide a procedure under which a

network pharmacy provider may challenge a listed maximum allowable cost price for a drug;

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

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

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

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

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

(viii) must provide a process for each of its network pharmacy providers to readily access the maximum allowable cost list specific to that provider;

(24) a requirement that the managed care organization and any entity with which the managed care organization contracts for the performance of services under a managed care plan disclose, at no cost, to the commission and, on request, the office of the

attorney general all discounts, incentives, rebates, fees, free goods, bundling arrangements, and other agreements affecting the net cost of goods or services provided under the plan; and

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

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

(B) the rate reductions are based on changes to the Medicaid fee schedule or cost containment initiatives implemented by the commission.

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

Sec. 533.0061. PROVIDER ACCESS STANDARDS; REPORT. (a) The commission shall establish minimum provider access standards for the provider network of a managed care organization that contracts with the commission to provide health care services to recipients. The access standards must ensure that a managed care organization provides recipients sufficient access to:

(1) preventive care;

(2) primary care;

(3) specialty care;

(4) after-hours urgent care;

(5) chronic care;

(6) long-term services and supports;

(7) nursing services;

(8) therapy services, including services provided in a clinical setting or in a home or community-based setting; and

(9) any other services identified by the commission.

(b) To the extent it is feasible, the access standards established under this section must:

(1) distinguish between access to providers in urban and rural settings; and

(2) consider the number and geographic distribution of Medicaid-enrolled providers in a particular region.

(c) The commission shall biennially submit to the legislature and make available to the public a report containing information and statistics about recipient access to providers through the provider networks of the managed care organizations. The report must contain:

(1) a compilation and analysis of information submitted to the commission under Section 533.005(a)(20)(D); and

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

Sec. 533.0062. CAPITATION PAYMENTS AT-RISK BASED ON COMPLIANCE WITH PROVIDER ACCESS STANDARDS. A contract between a managed care organization and the commission for the organization to provide health care services to recipients must place 0.5 percent of the organization's capitation payments at-risk based on compliance with the provider access standards established under

Section 533.0061. The commission shall:

(1) on a quarterly basis, assess whether an organization has complied with the provider access standards; and

(2) on an annual basis, pay the organization any money withheld under this section for each quarter in the preceding year in which the organization complied with the standards.

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

(1) subject to Subsection (c), updates the organization's provider network directory at least monthly; and

(2) in addition to making the directory available in paper form, makes the provider network directory available on the organization's Internet website.

(b) Notwithstanding Subsection (a):

(1) a managed care organization participating in the STAR Medicaid managed care program shall, for recipients in that program, send a paper form of the organization's provider network directory for the program only to a recipient who opts to receive the directory in paper form; and

(2) a managed care organization participating in the STAR + PLUS Medicaid managed care program shall, for a recipient in that program, issue a provider network directory for the program in paper form unless the recipient opts out of receiving the directory in paper form.

(c) Subsection (a)(1) does not require a managed care

organization to republish the organization's provider network directory in paper form each time the directory is updated.

Sec. 533.0064. EXPEDITED CREDENTIALING PROCESS FOR CERTAIN PROVIDERS. (a) In this section, "applicant provider" means a health care provider applying for expedited credentialing under this section.

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

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

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

(2) be a Medicaid-enrolled provider;

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

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

(d) On submission by the applicant provider of the

information required by the managed care organization under Subsection (c), and for Medicaid reimbursement purposes only, the organization shall treat the applicant provider as if the provider were in the organization's provider network when the applicant provider provides services to recipients.

(e) A managed care organization may not recover any payments from an applicant provider if, on completion of the credentialing process, the organization determines that the applicant provider does not meet the organization's credentialing requirements.

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

(l) The commission shall conduct direct monitoring of a managed care organization's provider network and providers in the network to ensure compliance with contractual obligations related to:

(1) the number of providers accepting new patients under the Medicaid program; and

(2) patient wait times.

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

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

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

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

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

SECTION 5. The Health and Human Services Commission shall submit to the legislature the initial report required under Section 533.0061(c), Government Code, as added by this Act, not later than December 1, 2016.

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

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