

By: Muñoz, Jr., Guerra

H.B. No. 1398

A BILL TO BE ENTITLED

AN ACT

relating to the processing and payment of claims for reimbursement by certain 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 on any claim for
9 payment that is received with documentation reasonably necessary
10 for the managed care organization to process the claim[+]

11 [~~(A)~~] not later than:

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

15 (B) on average, [~~(ii)~~] the 15th [~~30th~~] day
16 after the date the claim is received if the claim, including a claim
17 that relates to the provision of long-term services and supports,
18 is not subject to Paragraph (A) [~~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)(B) [~~(7)(A)(ii)~~] on average not later

1 than the 15th [~~21st~~] day after the date the claim is received by the
2 organization;

3 (7-b) a requirement that the managed care organization
4 allow a physician or provider to electronically submit
5 documentation necessary for the managed care organization to
6 process a claim for payment for health care services rendered to a
7 recipient under a managed care plan, including additional
8 documentation necessary when the claim is not submitted with
9 documentation reasonably necessary for the managed care
10 organization to process the claim;

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

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

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

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

27 (12) if the commission finds that a managed care

1 organization has violated Subdivision (11), a requirement that the
2 managed care organization reimburse an out-of-network provider for
3 health care services at a rate that is equal to the allowable rate
4 for those services, as determined under Sections 32.028 and
5 32.0281, Human Resources Code;

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

9 (A) use advanced practice registered nurses and
10 physician assistants in addition to physicians as primary care
11 providers to increase the availability of primary care providers in
12 the organization's provider network; and

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

16 (i) selection and assignment as primary
17 care providers;

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

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

22 (14) a requirement that the managed care organization
23 reimburse a federally qualified health center or rural health
24 clinic for health care services provided to a recipient outside of
25 regular business hours, including on a weekend day or holiday, at a
26 rate that is equal to the allowable rate for those services as
27 determined under Section 32.028, Human Resources Code, if the

1 recipient does not have a referral from the recipient's primary
2 care physician;

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

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

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

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

17 (D) the managed care organization to allow a
18 provider with a claim that has not been paid before the time
19 prescribed by Subdivision (7)(B) [~~(7)(A)(ii)~~] to initiate an appeal
20 of that claim;

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

25 (17) a requirement that the managed care organization
26 ensure that a medical director and patient care coordinators and
27 provider and recipient support services personnel are located in

1 the South Texas service region, if the managed care organization
2 provides a managed care plan in that region;

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

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

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

10 (A) develop and submit to the commission, before
11 the organization begins to provide health care services to
12 recipients, a comprehensive plan that describes how the
13 organization's provider network complies with the provider access
14 standards established under Section 533.0061, as added by Chapter
15 1272 (S.B. 760), Acts of the 84th Legislature, Regular Session,
16 2015;

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, as added by
21 Chapter 1272 (S.B. 760), Acts of the 84th Legislature, Regular
22 Session, 2015; and

23 (ii) make substantial efforts, as
24 determined by the commission, to mitigate or remedy any
25 noncompliance with the provider access standards established under
26 Section 533.0061, as added by Chapter 1272 (S.B. 760), Acts of the
27 84th Legislature, Regular Session, 2015;

1 (C) pay liquidated damages for each failure, as
2 determined by the commission, to comply with the provider access
3 standards established under Section 533.0061, as added by Chapter
4 1272 (S.B. 760), Acts of the 84th Legislature, Regular Session,
5 2015, in amounts that are reasonably related to the noncompliance;
6 and

7 (D) regularly, as determined by the commission,
8 submit to the commission and make available to the public a report
9 containing data on the sufficiency of the organization's provider
10 network with regard to providing the care and services described
11 under Section 533.0061(a), as added by Chapter 1272 (S.B. 760),
12 Acts of the 84th Legislature, Regular Session, 2015, and specific
13 data with respect to access to primary care, specialty care,
14 long-term services and supports, nursing services, and therapy
15 services on the average length of time between:

16 (i) the date a provider requests prior
17 authorization for the care or service and the date the organization
18 approves or denies the request; and

19 (ii) the date the organization approves a
20 request for prior authorization for the care or service and the date
21 the care or service is initiated;

22 (21) a requirement that the managed care organization
23 demonstrate to the commission, before the organization begins to
24 provide health care services to recipients, that, subject to the
25 provider access standards established under Section 533.0061, as
26 added by Chapter 1272 (S.B. 760), Acts of the 84th Legislature,
27 Regular Session, 2015:

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

4 (B) the organization's provider network
5 includes:

6 (i) a sufficient number of primary care
7 providers;

8 (ii) a sufficient variety of provider
9 types;

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

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

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

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

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

1 (B) focuses on measuring outcomes; and

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

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

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

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

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

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

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

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

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

26 (F) under which the managed care organization may
27 not prohibit, limit, or interfere with a recipient's selection of a

1 pharmacy or pharmacist of the recipient's choice for the provision
2 of pharmaceutical services under the plan through the imposition of
3 different copayments;

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

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

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

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

25 (I) under which the managed care organization may
26 include mail-order pharmacies in its networks, but may not require
27 enrolled recipients to use those pharmacies, and may not charge an

1 enrolled recipient who opts to use this service a fee, including
2 postage and handling fees;

3 (J) under which the managed care organization or
4 pharmacy benefit manager, as applicable, must pay claims and allow
5 the electronic submission of claims documentation in accordance
6 with Subdivisions (7) and (7-b) [Section 843.339, Insurance Code];
7 and

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

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

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

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

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

26 (iii) must review and update maximum
27 allowable cost price information at least once every seven days to

1 reflect any modification of maximum allowable cost pricing;

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

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

13 (vi) must:

14 (a) provide a procedure under which a
15 network pharmacy provider may challenge a listed maximum allowable
16 cost price for a drug;

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

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

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

27 (e) report to the commission every 90

1 days the total number of challenges that were made and denied in the
2 preceding 90-day period for each maximum allowable cost list drug
3 for which a challenge was denied during the period;

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

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

11 (24) a requirement that the managed care organization
12 and any entity with which the managed care organization contracts
13 for the performance of services under a managed care plan disclose,
14 at no cost, to the commission and, on request, the office of the
15 attorney general all discounts, incentives, rebates, fees, free
16 goods, bundling arrangements, and other agreements affecting the
17 net cost of goods or services provided under the plan;

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

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

24 (B) the rate reductions are based on changes to
25 the Medicaid fee schedule or cost containment initiatives
26 implemented by the commission; and

27 (26) a requirement that the managed care organization

1 make initial and subsequent primary care provider assignments and
2 changes.

3 SECTION 2. Subchapter B, Chapter 32, Human Resources Code,
4 is amended by adding Section 32.0292 to read as follows:

5 Sec. 32.0292. PAYMENT OF CERTAIN TRANSPORTATION CLAIMS.

6 The executive commissioner shall adopt rules to ensure the
7 commission or the commission's designee pays a claim for
8 nonemergency ambulance services provided to a recipient of medical
9 assistance under this chapter not later than the 15th day after the
10 date the claim for payment is received with documentation
11 reasonably necessary for the commission or the designee to process
12 the claim.

13 SECTION 3. The executive commissioner of the Health and
14 Human Services Commission shall adopt the rules necessary to
15 implement Section 32.0292, Human Resources Code, as added by this
16 Act, not later than October 1, 2017.

17 SECTION 4. (a) The Health and Human Services Commission, in
18 a contract between the commission and a managed care organization
19 under Chapter 533, Government Code, that is entered into or renewed
20 on or after the effective date of this Act, shall require that the
21 managed care organization comply with Sections 533.005(a)(7),
22 (7-a), and (23)(J), Government Code, as amended by this Act, and
23 Section 533.005(a)(7-b), Government Code, as added by this Act.

24 (b) The Health and Human Services Commission shall seek to
25 amend contracts entered into with managed care organizations under
26 Chapter 533, Government Code, before the effective date of this Act
27 to require that those managed care organizations comply with

1 Sections 533.005(a)(7), (7-a), and (23)(J), Government Code, as
2 amended by this Act, and Section 533.005(a)(7-b), Government Code,
3 as added by this Act. To the extent of a conflict between those
4 provisions and a provision of a contract with a managed care
5 organization entered into before the effective date of this Act,
6 the contract provision prevails.

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

13 SECTION 6. This Act takes effect September 1, 2017.