By: Raymond H.B. No. 3982

Substitute the following for H.B. No. 3982:

By: Minjarez C.S.H.B. No. 3982

A BILL TO BE ENTITLED

AN ACT

relating to the Medicaid program, including the administration and operation of the Medicaid managed care program.

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

SECTION 1. Section 531.024172, Government Code, is amended to read as follows:

Sec. 531.024172. ELECTRONIC VISIT VERIFICATION SYSTEM; REIMBURSEMENT OF CERTAIN RELATED CLAIMS. (a) Subject to Subsection (g), [~~In this section, "acute nursing services" has the meaning assigned by Section 531.02417.~~

[~~(b) If it is cost-effective and feasible,~~] the commission shall, in accordance with federal law, implement an electronic visit verification system to electronically verify [~~and document,~~] through a telephone, global positioning, or computer-based system that personal care services or attendant care services provided to recipients under Medicaid, including personal care services or attendant care services provided under the Texas Health Care Transformation and Quality Improvement Program waiver issued under Section 1115 of the federal Social Security Act (42 U.S.C. Section 1315) or any other Medicaid waiver program, are provided to recipients in accordance with a prior authorization or plan of care. The electronic visit verification system implemented under this subsection must allow for verification of only the following[~~, basic~~] information relating to the delivery of Medicaid [~~acute~~

~~nursing~~] services[~~, including~~]:

(1) the type of service provided [~~the provider's name~~];

(2) the name of the recipient to whom the service is provided [~~the recipient's name~~]; [~~and~~]

(3) the date and times [~~time~~] the provider began [~~begins~~] and ended the [~~ends each~~] service delivery visit;

(4) the location, including the address, at which the service was provided;

(5) the name of the individual who provided the service; and

(6) other information the commission determines is necessary to ensure the accurate adjudication of Medicaid claims.

(b) The commission shall establish minimum requirements for third-party entities seeking to provide electronic visit verification system services to health care providers providing Medicaid services and must certify that a third-party entity complies with those minimum requirements before the entity may provide electronic visit verification system services to a health care provider.

(c) The commission shall inform each Medicaid recipient who receives personal care services or attendant care services that the health care provider providing the services and the recipient are each required to comply with the electronic visit verification system. A managed care organization that contracts with the commission to provide health care services to Medicaid recipients described by this subsection shall also inform recipients enrolled

in a managed care plan offered by the organization of those requirements.

(d) In implementing the electronic visit verification system:

(1) subject to Subsection (e), the executive commissioner shall adopt compliance standards for health care providers; and

(2) the commission shall ensure that:

(A) the information required to be reported by health care providers is standardized across managed care organizations that contract with the commission to provide health care services to Medicaid recipients and across commission programs; and

(B) time frames for the maintenance of electronic visit verification data by health care providers align with claims payment time frames.

(e) In establishing compliance standards for health care providers under this section, the executive commissioner shall consider:

(1) the administrative burdens placed on health care providers required to comply with the standards; and

(2) the benefits of using emerging technologies for ensuring compliance, including Internet-based, mobile telephone-based, and global positioning-based technologies.

(f) A health care provider that provides personal care services or attendant care services to Medicaid recipients shall:

(1) use an electronic visit verification system to

document the provision of those services;

(2) comply with all documentation requirements established by the commission;

(3) comply with applicable federal and state laws regarding confidentiality of recipients' information;

(4) ensure that the commission or the managed care organization with which a claim for reimbursement for a service is filed may review electronic visit verification system documentation related to the claim or obtain a copy of that documentation at no charge to the commission or the organization; and

(5) at any time, allow the commission or a managed care organization with which a health care provider contracts to provide health care services to recipients enrolled in the organization's managed care plan to have direct, on-site access to the electronic visit verification system in use by the health care provider.

(g) The commission may recognize a health care provider's proprietary electronic visit verification system as complying with this section and allow the health care provider to use that system for a period determined by the commission if the commission determines that the system:

(1) complies with all necessary data submission, exchange, and reporting requirements established under this section;

(2) meets all other standards and requirements established under this section; and

(3) has been in use by the health care provider since

at least June 1, 2014.

(h) The commission or a managed care organization that contracts with the commission to provide health care services to Medicaid recipients may not pay a claim for reimbursement for personal care services or attendant care services provided to a recipient unless the information from the electronic visit verification system corresponds with the information contained in the claim and the services were provided consistent with a prior authorization or plan of care. A previously paid claim is subject to retrospective review and recoupment if unverified.

(i) The commission shall create a stakeholder work group comprised of representatives of affected health care providers, managed care organizations, and Medicaid recipients and periodically solicit from that work group input regarding the ongoing operation of the electronic visit verification system under this section.

(j) The executive commissioner may adopt rules necessary to implement this section.

SECTION 2. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1133 to read as follows:

Sec. 531.1133. PROVIDER NOT LIABLE FOR MANAGED CARE ORGANIZATION OVERPAYMENT OR DEBT. (a) If the commission's office of inspector general makes a determination to recoup an overpayment or debt from a managed care organization that contracts with the commission to provide health care services to Medicaid recipients, a provider that contracts with the managed care organization may not be held liable for the good faith provision of services under

the provider's contract with the managed care organization that were provided with prior authorization.

(b) This section does not:

(1) limit the office of inspector general's authority to recoup an overpayment or debt from a provider that is owed by the provider as a result of the provider's failure to comply with applicable law or a contract provision, notwithstanding any prior authorization for a service provided; or

(2) apply to an action brought under Chapter 36, Human Resources Code.

SECTION 3. Section 531.120, Government Code, is amended by adding Subsection (c) to read as follows:

(c) The commission shall provide the notice required by Subsection (a) to a provider that is a hospital not later than the 90th day before the date the overpayment or debt that is the subject of the notice must be paid.

SECTION 4. Section 533.00281, Government Code, is redesignated as Section 533.0121, Government Code, and amended to read as follows:

Sec. 533.0121 [~~533.00281~~]. UTILIZATION REVIEW AND FINANCIAL AUDIT PROCESS FOR [~~STAR + PLUS~~] MEDICAID MANAGED CARE ORGANIZATIONS CONDUCTED BY OFFICE OF CONTRACT MANAGEMENT. (a) The commission's office of contract management shall establish an annual utilization review and financial audit process for managed care organizations participating in the [~~STAR + PLUS~~] Medicaid managed care program. The commission shall determine the topics to be examined in a [~~the~~] review [~~process~~], except that with respect to

a managed care organization participating in the STAR + PLUS Medicaid managed care program, the review [~~process~~] must include a thorough investigation of the [~~each managed care~~] organization's procedures for determining whether a recipient should be enrolled in the STAR + PLUS home and community-based services and supports (HCBS) program, including the conduct of functional assessments for that purpose and records relating to those assessments.

(b) The office of contract management shall use the utilization review and financial audit process established under this section to review each fiscal year:

(1) each managed care organization [~~every managed care organization~~] participating in the [~~STAR + PLUS~~] Medicaid managed care program in this state for that organization's first five years of participation; [~~or~~]

(2) each managed care organization providing health care services to a population of recipients new to receiving those services through a Medicaid [~~only the~~] managed care delivery model for the first three years that organization provides those services to that population; or

(3) managed care organizations that, using a risk-based assessment process and evaluation of prior history, the office determines have a higher likelihood of contract or financial noncompliance [~~inappropriate client placement in the STAR + PLUS home and community-based services and supports (HCBS) program~~].

(c) In addition to the reviews required by Subsection (b), the office of contract management shall use the utilization review and financial audit process established under this section to

review each managed care organization participating in the Medicaid managed care program at least once every five years.

(d) In conjunction with the commission's office of contract management, the commission shall provide a report to the standing committees of the senate and house of representatives with jurisdiction over Medicaid not later than December 1 of each year. The report must:

(1) summarize the results of the [~~utilization~~] reviews conducted under this section during the preceding fiscal year;

(2) provide analysis of errors committed by each reviewed managed care organization; and

(3) extrapolate those findings and make recommendations for improving the efficiency of the Medicaid managed care program.

(e) If a [~~utilization~~] review conducted under this section results in a determination to recoup money from a managed care organization, the provider protections from liability under Section 531.1133 apply [~~a service provider who contracts with the managed care organization may not be held liable for the good faith provision of services based on an authorization from the managed care organization~~].

SECTION 5. Section 533.005, Government Code, is amended by amending Subsection (a) and adding Subsection (d) 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 access to and 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) subject to Subdivision (7-b), 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 offered by the managed care organization 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; and

(B) on average, not later than [~~(ii)~~] the 15th [~~30th~~] day after the date the claim is received if the claim, including a claim that relates to the provision of long-term services and supports, is not subject to Paragraph (A) [~~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 to which [~~described by~~] Subdivision (7)(B) applies [~~(7)(A)(ii)~~] on average not later than the 15th [~~21st~~] day after the date the claim is received by the organization;

(7-b) a requirement that the managed care organization demonstrate to the commission that, within each provider category and service delivery area designated by the commission, the organization pays at least 98 percent of claims within the times prescribed by Subdivision (7);

(7-c) a requirement that the managed care organization establish an electronic process for use by providers in submitting claims documentation that complies with Section 533.0055(b)(6) and

allows providers to submit additional documentation on a claim when the organization determines the claim was not submitted with documentation reasonably necessary to process the claim;

(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 utilization [~~usages~~] of out-of-network providers or groups of out-of-network providers may not exceed limits determined by the commission, including limits [~~for those usages~~] relating to:

(A) total inpatient admissions, total outpatient services, and emergency room admissions [~~determined by the commission~~];

(B) acute care services not described by Paragraph (A); and

(C) long-term services and supports;

(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 complaints and appeals related to claims payment and prior authorization and service denials, including a system [~~process~~] that will [~~require~~]:

(A) allow providers to electronically track and determine [~~a tracking mechanism to document~~] the status and final disposition of the [~~each~~] provider's [~~claims payment~~] appeal or complaint, as applicable;

(B) require the contracting with physicians or other health care providers who are not network providers and who are of the same or related specialty as the appealing physician or other provider, as appropriate, to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a provider appeal; and

(C) require the determination of the physician or other health care provider resolving the dispute to be binding on the managed care organization and the appealing 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;~~]

(15-a) a requirement that the managed care organization make available on the organization's Internet website summary information that is accessible to the public regarding the number of provider appeals and the disposition of those appeals, organized by provider and service types;

(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 Medicaid services to recipients [~~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 provider access standards established under Section 533.0061, as added by Chapter 1272 (S.B. 760), Acts of the 84th Legislature, Regular Session, 2015;

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

(i) continue to comply with the provider

access standards established under Section 533.0061, as added by Chapter 1272 (S.B. 760), Acts of the 84th Legislature, Regular Session, 2015; and

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

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

(D) annually [~~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), as added by Chapter 1272 (S.B. 760), Acts of the 84th Legislature, Regular Session, 2015, and specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on:

(i) the average length of time between[~~:~~

[~~(i)~~] the date a provider requests prior authorization for the care or service and the date the organization approves or denies the request; [~~and~~]

(ii) the average length of time between the date the organization approves a request for prior authorization for the care or service and the date the care or service is initiated; and

(iii) the number of providers who are accepting new patients;

(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 provider access standards established under Section 533.0061, as added by Chapter 1272 (S.B. 760), Acts of the 84th Legislature, Regular Session, 2015:

(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 Medicaid;

(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; and~~

[~~(26) a requirement that the managed care organization~~] make initial and subsequent primary care provider assignments and changes.

(d) In addition to the requirements specified by Subsection (a), a contract described by that subsection must provide that if the managed care organization has an ownership interest in a health care provider in the organization's provider network, the organization:

(1) must include in the provider network at least one other health care provider of the same type in which the organization does not have an ownership interest unless the organization is able to demonstrate to the commission that the provider included in the provider network is the only provider located in an area that meets requirements established by the commission relating to the time and distance a recipient is expected to travel to receive services; and

(2) may not give preference in authorizing referrals to the provider in which the organization has an ownership interest

as compared to other providers of the same or similar services participating in the organization's provider network.

SECTION 6. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00541 to read as follows:

Sec. 533.00541. PRIOR AUTHORIZATION REQUIREMENTS FOR CERTAIN POST-ACUTE CARE SERVICES. Notwithstanding any other law and except as otherwise provided by a settlement agreement filed with and approved by a court, the commission shall require a managed care organization that contracts with the commission to provide health care services to recipients to:

(1) approve or pend a request from a provider of acute care inpatient services for prior authorization for the following services or equipment not later than 72 hours after receiving the request to allow for a safe and timely discharge of a patient from an inpatient facility:

(A) home health services;

(B) long-term services and supports, including care provided through a nursing facility;

(C) private-duty nursing;

(D) therapy services; and

(E) durable medical equipment;

(2) ensure that a provider described by Subdivision (1) has an opportunity to engage in direct discussions with the organization regarding the appropriate level of post-acute care while a request for prior authorization is pending;

(3) contact, notify, and negotiate with a provider described by Subdivision (1) before approving a prior authorization

request for personal care services or attendant care services with an expiration date different from the expiration date requested by the provider;

(4) submit to a provider of personal care services or attendant care services any change to a recipient's service plan relating to personal care services or attendant care services not later than the fifth day before the date the plan is to be effective for purposes of giving the provider time to initiate the change and the recipient an opportunity to agree to the change, unless the organization is changing the plan in order to meet an emerging need for personal care services or attendant care services;

(5) include on subsequent prior authorization requests approved with a retroactive effective date an expiration date that takes into account the date the service change described by Subdivision (4) was implemented by the provider; and

(6) provide complete electronic access to prior authorizations through the organization's process required under Section 533.005(a)(7-c).

SECTION 7. Section 533.0055(b), Government Code, is amended to read as follows:

(b) The provider protection plan required under this section must provide for:

(1) prompt payment and proper reimbursement of providers by managed care organizations;

(2) prompt and accurate adjudication of claims through:

(A) provider education on the proper submission

of clean claims and on appeals;

(B) acceptance of uniform forms, including HCFA Forms 1500 and UB-92 and subsequent versions of those forms, through an electronic portal; and

(C) the establishment of standards for claims payments in accordance with a provider's contract;

(3) adequate and clearly defined provider network standards that are specific to provider type, including physicians, general acute care facilities, and other provider types defined in the commission's network adequacy standards [~~in effect on January 1, 2013~~], and that ensure choice among multiple providers to the greatest extent possible;

(4) a prompt credentialing process for providers;

(5) uniform efficiency standards and requirements for managed care organizations for the submission and electronic tracking of prior authorization [~~preauthorization~~] requests for services provided under Medicaid;

(6) establishment of an electronic process, including the use of an Internet portal, through which providers in any managed care organization's provider network may:

(A) submit electronic claims, prior authorization request forms and attachments [~~requests~~], claims appeals and reconsiderations, clinical data, and other documentation that the managed care organization requests for prior authorization and claims processing, including an electronic process that allows for the resubmission of a claim without a requirement that the resubmitted claim be submitted in paper form

in order to avoid treatment of the resubmitted claim as a duplicate claim; and

(B) obtain electronic remittance advice documents, explanation of benefits statements, service plans under the STAR Kids Medicaid managed care program, and other standardized reports;

(7) the measurement of the rates of retention by managed care organizations of significant traditional providers;

(8) the creation of a work group to review and make recommendations to the commission concerning any requirement under this subsection for which immediate implementation is not feasible at the time the plan is otherwise implemented, including the required process for submission and acceptance of attachments for claims processing and prior authorization requests through an electronic process under Subdivision (6) and, for any requirement that is not implemented immediately, recommendations regarding the expected:

(A) fiscal impact of implementing the requirement; and

(B) timeline for implementation of the requirement; and

(9) any other provision that the commission determines will ensure efficiency or reduce administrative burdens on providers participating in a Medicaid managed care model or arrangement.

SECTION 8. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0058 to read as follows:

Sec. 533.0058. RESTRICTIONS ON CERTAIN REIMBURSEMENT RATE REDUCTIONS. (a) In this section, "across-the-board provider reimbursement rate reduction" means a provider reimbursement rate reduction proposed by a managed care organization that the commission determines is likely to affect more than 50 percent of a particular type of provider participating in the organization's provider network during the 12-month period following implementation of the proposed reduction, regardless of whether:

(1) the organization limits the proposed reduction to specific service areas or provider types; or

(2) the affected providers are likely to experience differing percentages of rate reductions or amounts of lost revenue as a result of the proposed reduction.

(b) Except as provided by Subsection (e), a managed care organization that contracts with the commission to provide health care services to recipients may not implement a significant, as determined by the commission, across-the-board provider reimbursement rate reduction unless the organization:

(1) at least 90 days before the proposed rate reduction is to take effect:

(A) provides the commission and affected providers with written notice of the proposed rate reduction; and

(B) makes a good faith effort to negotiate the reduction with the affected providers; and

(2) receives prior approval from the commission, subject to Subsection (c).

(c) An across-the-board provider reimbursement rate

reduction is considered to have received the commission's prior approval for purposes of Subsection (b)(2) unless the commission issues a written statement of disapproval not later than the 45th day after the date the commission receives notice of the proposed rate reduction from the managed care organization under Subsection (b)(1)(A).

(d) If a managed care organization proposes an across-the-board provider reimbursement rate reduction in accordance with this section and subsequently rejects alternative rate reductions suggested by an affected provider, the organization must provide the provider with written notice of that rejection, including an explanation of the grounds for the rejection, before implementing any rate reduction.

(e) This section does not apply to rate reductions that are implemented because of reductions to the Medicaid fee schedule or cost containment initiatives that are specifically directed by the legislature and implemented by the commission.

SECTION 9. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00611 to read as follows:

Sec. 533.00611. STANDARDS FOR DETERMINING MEDICAL NECESSITY. (a) Except as provided by Subsection (b), the commission shall establish standards that govern the processes, criteria, and guidelines under which managed care organizations determine the medical necessity of a health care service covered by Medicaid. In establishing standards under this section, the commission shall:

(1) ensure that each recipient has equal access in

scope and duration to the same covered health care services for which the recipient is eligible, regardless of the managed care organization with which the recipient is enrolled;

(2) provide managed care organizations with flexibility to approve covered medically necessary services for recipients that may not be within prescribed criteria and guidelines;

(3) require managed care organizations to make available to providers all criteria and guidelines used to determine medical necessity through an Internet portal accessible by the providers;

(4) ensure that managed care organizations consistently apply the same medical necessity criteria and guidelines for the approval of services and in retrospective utilization reviews; and

(5) ensure that managed care organizations include in any service or prior authorization denial specific information about the medical necessity criteria or guidelines that were not met.

(b) This section does not apply to or affect the commission's authority to:

(1) determine medical necessity for home and community-based services provided under the STAR + PLUS Medicaid managed care program; or

(2) conduct utilization reviews of those services.

SECTION 10. Section 533.0071, Government Code, is amended to read as follows:

Sec. 533.0071. ADMINISTRATION OF CONTRACTS. The commission shall make every effort to improve the administration of contracts with managed care organizations. To improve the administration of these contracts, the commission shall:

(1) ensure that the commission has appropriate expertise and qualified staff to effectively manage contracts with managed care organizations under the Medicaid managed care program;

(2) evaluate options for Medicaid payment recovery from managed care organizations if the enrollee dies or is incarcerated or if an enrollee is enrolled in more than one state program or is covered by another liable third party insurer;

(3) maximize Medicaid payment recovery options by contracting with private vendors to assist in the recovery of capitation payments, payments from other liable third parties, and other payments made to managed care organizations with respect to enrollees who leave the managed care program;

(4) decrease the administrative burdens of managed care for the state, the managed care organizations, and the providers under managed care networks to the extent that those changes are compatible with state law and existing Medicaid managed care contracts, including decreasing those burdens by:

(A) where possible, decreasing the duplication of administrative reporting and process requirements for the managed care organizations and providers, such as requirements for the submission of encounter data, quality reports, historically underutilized business reports, and claims payment summary reports;

(B) allowing managed care organizations to provide updated address and other contact information directly to the commission for correction in the state eligibility system;

(C) promoting consistency and uniformity among managed care organization policies, including policies relating to the prior authorization processes [~~preauthorization process~~], lengths of hospital stays, filing deadlines, levels of care, and case management services; and

(D) [~~reviewing the appropriateness of primary care case management requirements in the admission and clinical criteria process, such as requirements relating to including a separate cover sheet for all communications, submitting handwritten communications instead of electronic or typed review processes, and admitting patients listed on separate notifications; and~~

[~~(E)~~] providing a portal that complies with Section 533.0055(b)(6) through which providers in any managed care organization's provider network may submit acute care services and long-term services and supports claims; and

(5) reserve the right to amend the managed care organization's process for resolving provider appeals of denials based on medical necessity to include an independent review process established by the commission for final determination of these disputes.

SECTION 11. Section 533.0076, Government Code, is amended by amending Subsection (c) and adding Subsection (d) to read as follows:

(c) The commission shall allow a recipient who is enrolled in a managed care plan under this chapter to disenroll from that plan and enroll in another managed care plan[~~:~~

[~~(1)~~] at any time for cause in accordance with federal law, including because:

(1) the recipient moves out of the managed care organization's service area;

(2) the plan does not, on the basis of moral or religious objections, cover the service the recipient seeks;

(3) the recipient needs related services to be performed at the same time, not all related services are available within the organization's provider network, and the recipient's primary care provider or another provider determines that receiving the services separately would subject the recipient to unnecessary risk;

(4) for recipients of long-term services or supports, the recipient would have to change the recipient's residential, institutional, or employment supports provider based on that provider's change in status from an in-network to an out-of-network provider with the managed care organization and, as a result, would experience a disruption in the recipient's residence or employment; or

(5) of another reason permitted under federal law, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the recipient's care needs[~~; and~~

[~~(2) once for any reason after the periods described~~

~~by Subsections (a) and (b)~~].

(d) The commission shall implement a process by which the commission verifies that a recipient is permitted to disenroll from one managed care plan offered by a managed care organization and enroll in another managed care plan, including a plan offered by another managed care organization, before the disenrollment occurs.

SECTION 12. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0091 to read as follows:

Sec. 533.0091. CARE COORDINATION SERVICES. A managed care organization that contracts with the commission to provide health care services to recipients shall ensure that persons providing care coordination services through the organization coordinate with hospital discharge planners, who must notify the organization of an inpatient admission of a recipient, to facilitate the timely discharge of the recipient to the appropriate level of care and minimize potentially preventable readmissions.

SECTION 13. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0122 to read as follows:

Sec. 533.0122. UTILIZATION REVIEW AUDITS CONDUCTED BY OFFICE OF INSPECTOR GENERAL. (a) If the commission's office of inspector general intends to conduct a utilization review audit of a provider of services under a Medicaid managed care delivery model, the office shall inform both the provider and the managed care organization with which the provider contracts of any applicable criteria and guidelines the office will use in the course of the audit.

(b) The commission's office of inspector general shall ensure that each person conducting a utilization review audit under this section has experience and training regarding the operations of managed care organizations.

(c) The commission's office of inspector general may not, as the result of a utilization review audit, recoup an overpayment or debt from a provider that contracts with a managed care organization based on a determination that a provided service was not medically necessary unless the office:

(1) uses the same criteria and guidelines that were used by the managed care organization in its determination of medical necessity for the service; and

(2) verifies with the managed care organization and the provider that the provider:

(A) at the time the service was delivered, had reasonable notice of the criteria and guidelines used by the managed care organization to determine medical necessity; and

(B) did not follow the criteria and guidelines used by the managed care organization to determine medical necessity that were in effect at the time the service was delivered.

(d) If the commission's office of inspector general conducts a utilization review audit that results in a determination to recoup money from a managed care organization that contracts with the commission to provide health care services to recipients, the provider protections from liability under Section 531.1133 apply.

SECTION 14. Subchapter A, Chapter 533, Government Code, is

amended by adding Section 533.01316 to read as follows:

Sec. 533.01316. MANAGED CARE ORGANIZATION POLICIES FOR CERTAIN HOSPITAL STAYS. The commission shall ensure that managed care organizations that contract with the commission to provide health care services to recipients have policies regarding treatment and services related to a recipient's inpatient hospital stay, including a behavioral health hospital stay, that is less than 48 hours. For purposes of this section, the commission shall ensure that the organization:

(1) specifies criteria that:

(A) warrant reimbursement of services related to the stay as either inpatient hospital services or outpatient hospital services, including criteria for determining what services constitute outpatient observation services;

(B) account for medical necessity based on recognized inpatient criteria, the severity of any psychological disorder, and the judgment of the treating physician or other provider; and

(C) do not permit classification of services as either inpatient or outpatient hospital services for purposes of reimbursement based solely on the duration of the stay;

(2) provides an opportunity for direct discussions regarding the medical necessity of a recipient's inpatient hospital admission; and

(3) reviews documentation in a recipient's medical record that supports the medical necessity of the inpatient hospital stay at the time of admission for reimbursement of

services related to the stay.

SECTION 15. Subchapter B, Chapter 534, Government Code, is amended by adding Section 534.0511 to read as follows:

Sec. 534.0511. ENSURING PROVISION OF MEDICALLY NECESSARY SERVICES. (a) This section applies only to an individual with an intellectual or developmental disability who is receiving services under a Medicaid waiver program or ICF-IID program and who requires medically necessary acute care services or long-term services and supports that are not available to the individual through the delivery model implemented under this chapter.

(b) Notwithstanding any other law, the Medicaid waiver program or ICF-IID program that serves an individual to which this section applies shall pay the cost of the service and may submit to the commission a claim for reimbursement for the cost of that service.

(c) If the commission determines that a claim paid by the commission under Subsection (b) should have been covered and paid by a managed care organization that contracts with the commission, the commission may recoup the entire cost of that claim from the organization.

SECTION 16. (a) In this section, "commission" and "Medicaid" have the meanings assigned by Section 531.001, Government Code.

(b) As soon as practicable after the effective date of this Act, the commission shall develop and implement a pilot program in up to three urban service delivery areas that is designed to increase the incidence of ambulance service providers directing

recipients of Medicaid managed care program services who are experiencing a behavioral health emergency to more appropriate health care providers for treatment of behavioral health illnesses.

(c) Not later than December 1, 2018, the commission shall develop a report analyzing any cost savings and other benefits realized as a result of the pilot program and deliver a copy of the report to the governor, lieutenant governor, speaker of the house of representatives, and chairs of the standing legislative committees having primary jurisdiction over Medicaid.

(d) This section expires January 1, 2019.

SECTION 17. (a) In this section, "commission" and "Medicaid" have the meanings assigned by Section 531.001, Government Code.

(b) Not later than November 30, 2017, the commission shall, consistent with the purpose of Sections 533.0025(b) and (d), Government Code, conduct a study to determine the cost-effectiveness and feasibility of providing prescription drug benefits to recipients of acute care services under Medicaid by pharmacies with a Class A pharmacy license, as described by Section 560.051, Occupations Code, through a single statewide prescription drug administrator that adheres to a pharmacy services reimbursement methodology that uses:

(1) the most accurate and transparent ingredient drug pricing model;

(2) the National Average Drug Acquisition Cost published by the Centers for Medicare and Medicaid Services as the drug acquisition cost; and

(3) the most recent dispensing fee study contracted for by the commission to set an accurate and transparent professional dispensing fee as defined by 1 T.A.C. Section 355.8551.

(c) In conducting a study under this section, the commission shall:

(1) for purposes of determining cost-effectiveness, assume and calculate reductions to the anticipated capitation rate paid to Medicaid managed care organizations, including reductions resulting from:

(A) the elimination or reduction of the per member per month administrative expense fee and the consolidation of the contracts relating to the prescription drug benefits;

(B) the elimination of the guaranteed risk margin; and

(C) any difference between pharmacy premiums paid by the commission to managed care organizations and prescription expenses reported by the managed care organizations for the preceding four fiscal years;

(2) determine and consider cost savings that would be achieved through maintaining a single pharmacy claims database to enhance patient quality outcomes through implementation of:

(A) a medication therapy management program;

(B) a prescription monitoring program;

(C) an adverse drug interaction avoidance program; or

(D) other similar results-oriented programs

based on pay-for-performance outcome models;

(3) determine and consider cost savings associated with enhancing system audit capabilities and reducing contractor and subcontractor noncompliance, including enhanced auditing capabilities and reducing noncompliance in relation to:

(A) the payment of rebates;

(B) drug utilization;

(C) the use of prior authorization; and

(D) claims adjudication;

(4) determine and consider cost savings associated with improving patient access to prescribed medications;

(5) determine and consider cost savings related to further streamlining both the fee-for-service and managed care prescription drug benefits under one contract;

(6) assume that the administrator described by Subsection (b) of this section is, if advantageous to the state, subject to Chapter 222, Insurance Code; and

(7) consider and determine whether the administrator could be excluded from Section 9010 of the federal Patient Protection and Affordable Care Act (Pub. L. No. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152).

(d) This section does not apply to and the commission may not consider in conducting the study required by this section the provision of prescription drug benefits by long-term care facility pharmacies and specialty pharmacies.

(e) The commission shall combine the study required by this

section with any other similar study required to be conducted by the commission.

(f) Not later than November 30, 2017, the commission shall report its findings under this section to the legislature.

(g) This section expires December 31, 2017.

SECTION 18. Section 533.005(a-3), Government Code, is repealed.

SECTION 19. As soon as practicable after the effective date of this Act, the Health and Human Services Commission shall implement an electronic visit verification system in accordance with Section 531.024172, Government Code, as amended by this Act.

SECTION 20. Section 533.005, Government Code, as amended by this Act, applies to a contract entered into or renewed on or after the effective date of this Act. A contract entered into or renewed before that date is governed by the law in effect on the date the contract was entered into or renewed, and that law is continued in effect for that purpose.

SECTION 21. 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 22. This Act takes effect September 1, 2017.