By: Hinojosa S.B. No. 1776

A BILL TO BE ENTITLED

AN ACT

relating to the administration and operation of the Medicaid program in a managed care model.

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

SECTION 1. 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. 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 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.

SECTION 2. 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 3. Section 533.005, Government Code, is amended by amending Subsections (a) and (a-3) and adding Subsections (a-4), (a-5), and (e) 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 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;

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

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

(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 determined by the commission, including limits relating to:

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

(B) therapy services, home health services, long-term services and supports, and health care specialists;

(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 and other health care providers 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 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 develop, implement, and maintain on the organization's Internet website information that is accessible to the public regarding 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 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) 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;

(25) a requirement that the managed care organization not implement significant, [~~nonnegotiated,~~] across-the-board provider reimbursement rate reductions unless the organization presented the reduction to providers in an attempt to negotiate the reductions and:

(A) subject to Subsection (a-4) [~~(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.

(a-3) For purposes of Subsection (a)(25), "across-the-board provider reimbursement rate reductions" means provider reimbursement rate reductions proposed by a managed care organization that the commission determines are likely to affect a substantial number of providers in the organization's provider network during the 12-month period following implementation of the proposed reductions, regardless of whether:

(1) the organization limits the proposed reductions 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 reductions.

(a-4) A [~~(a)(25)(A), a~~] provider reimbursement rate reduction is considered to have received the commission's prior approval for purposes of Subsection (a)(25) 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.

(a-5) If a managed care organization proposes provider reimbursement rate reductions in accordance with Subsection (a)(25) and subsequently rejects alternative rate reductions suggested by an affected provider, the managed care organization must provide the provider with written notice of that rejection,

including an explanation of the grounds for the rejection, prior to implementing any rate reductions.

(e) 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 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.

SECTION 4. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00541 to read as follows:

Sec. 533.00541. PRIOR AUTHORIZATION REQUIREMENTS. Notwithstanding any other law, the commission shall require a managed care organization that contracts with the commission to provide health care services to recipients to:

(1) approve or deny a request from a provider of acute care inpatient services for prior authorization for the following services or equipment not later than 48 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) contact, notify, and negotiate with a provider

before approving a prior authorization request with an expiration date different from the expiration date requested by the provider;

(3) submit to a provider agency any change to a recipient's service plan not later than the 5th 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;

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

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

SECTION 5. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00611 to read as follows:

Sec. 533.00611. MINIMUM STANDARDS FOR DETERMINING MEDICAL NECESSITY. The commission shall establish minimum standards for determining the medical necessity of a health care service covered by Medicaid. In establishing minimum standards under this section, the commission shall ensure that each recipient has equal access to the same covered health care services regardless of the managed care plan in which the recipient is enrolled.

SECTION 6. 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:

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

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

(C) 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;

(D) 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

(E) 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 and enroll in another plan before the disenrollment occurs.

SECTION 7. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.0091 and 533.01316 to read as follows:

Sec. 533.0091. CARE COORDINATION SERVICES. A managed care organization under contract 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 to facilitate the timely discharge of recipients to the appropriate level of care and minimize potentially preventable readmissions.

Sec. 533.01316. REIMBURSEMENT FOR CERTAIN HOSPITAL STAYS. The commission by rule shall adopt criteria to be used by managed care organizations under contract with the commission to provide health care services to recipients for the reimbursement of services provided to recipients for treatment related to an inpatient hospital stay, including a behavioral health hospital stay, that is less than 72 hours. The rules adopted under this section:

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

(2) must, in identifying criteria under Subdivision

(1), 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;

(3) may not allow for the classification of services as either inpatient or outpatient hospital services for purposes of reimbursement based solely on the duration of the stay; and

(4) require 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 8. 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 through which 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.

SECTION 9. 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 10. 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 11. This Act takes effect September 1, 2017.