By: Davis of Harris H.B. No. 2453

A BILL TO BE ENTITLED

AN ACT

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

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

SECTION 1. Section 531.001, Government Code, is amended by adding Subdivision (4-c) to read as follows:

(4-c) "Medicaid managed care organization" means a managed care organization as defined by Section 533.001 that contracts with the commission under Chapter 533 to provide health care services to Medicaid recipients.

SECTION 2. Subchapter A, Chapter 531, Government Code, is amended by adding Section 531.0172 to read as follows:

Sec. 531.0172. OMBUDSMAN FOR MEDICAID PROVIDERS. (a) In this section, "office" means the office of ombudsman for Medicaid providers.

(b) The office of ombudsman for Medicaid providers is established within the commission's office of inspector general to support Medicaid providers in resolving disputes, complaints, or other issues between the provider and the commission or a Medicaid managed care organization under a Medicaid managed care or fee-for-service delivery model.

(c) The staff of the office shall work in conjunction with the other staff of the office of inspector general to ensure that, in assessing administrative penalties otherwise authorized by law

1 on behalf of the commission or a health and human services agency,
2 the office of inspector general assesses penalties against a
3 Medicaid managed care organization for a rule violation that
4 results in a provider dispute or complaint in an amount that is
5 sufficient to deter future violations.
6 (d) The office shall report issues regarding the Medicaid
7 managed care program to the Medicaid director with timely
8 information.
9 (e) The office shall provide feedback to a person who files
10 a grievance with the office, such as feedback concerning any
11 investigation resulting from and the outcome of the grievance, in
12 accordance with the no-wrong-door system established under Section
13 533.027.
14 (f) Data collected by the office must be collected and
15 reported by provider type and population served. The office shall
16 use the data to develop and make to the commission's Medicaid and
17 CHIP services division recommendations for reforming providers'
18 experiences with Medicaid, including Medicaid managed care.
19 (g) The executive commissioner shall adopt rules as
20 necessary to implement this section.
21 SECTION 3. Subchapter B, Chapter 531, Government Code, is
22 amended by adding Section 531.02133 to read as follows:
23 Sec. 531.02133. REQUESTING INFORMATION IN STAR HEALTH
24 PROGRAM. The commission shall provide clear guidance on the
25 process for requesting and responding to requests for documents
26 relating to and medical records of a recipient under the STAR Health
27 program to:

(1) a Medicaid managed care organization that provides health care services under that program; and

(2) attorneys ad litem representing recipients under that program.

SECTION 4. Section 531.02141, Government Code, is amended by adding Subsection (f) to read as follows:

(f) For each hearing officer that conducts Medicaid fair hearings, the commission or the third-party arbiter described by Section 533.00715 annually shall collect data regarding the officer's decisions and rate of upholding or reversing decisions on appeal. The commission or third-party arbiter shall analyze the data to identify outliers. The third-party arbiter shall provide corrective education to hearing officers whose decisions or rates are outliers.

SECTION 5. Section 531.024, Government Code, is amended by adding Subsection (c) to read as follows:

(c) The rules promulgated under Subsection (a)(7) must provide a Medicaid recipient the right to an in-person hearing, regardless of whether the recipient demonstrates good cause.

SECTION 6. Section 531.02411, Government Code, is amended to read as follows:

Sec. 531.02411. STREAMLINING ADMINISTRATIVE PROCESSES. (a) The commission shall make every effort using the commission's existing resources to reduce the paperwork and other administrative burdens placed on Medicaid recipients and providers and other participants in Medicaid and shall use technology and efficient business practices to decrease those burdens. In addition, the

commission shall make every effort to improve the business practices associated with the administration of Medicaid by any method the commission determines is cost-effective, including:

(1) expanding the utilization of the electronic claims payment system;

(2) developing an Internet portal system for prior authorization requests;

(3) encouraging Medicaid providers to submit their program participation applications electronically;

(4) ensuring that the Medicaid provider application is easy to locate on the Internet so that providers may conveniently apply to the program;

(5) working with federal partners to take advantage of every opportunity to maximize additional federal funding for technology in Medicaid; and

(6) encouraging the increased use of medical technology by providers, including increasing their use of:

(A) electronic communications between patients and their physicians or other health care providers;

(B) electronic prescribing tools that provide up-to-date payer formulary information at the time a physician or other health care practitioner writes a prescription and that support the electronic transmission of a prescription;

(C) ambulatory computerized order entry systems that facilitate physician and other health care practitioner orders at the point of care for medications and laboratory and radiological tests;

1 (D) inpatient computerized order entry systems
2 to reduce errors, improve health care quality, and lower costs in a
3 hospital setting;
4 (E) regional data-sharing to coordinate patient
5 care across a community for patients who are treated by multiple
6 providers; and
7 (F) electronic intensive care unit technology to
8 allow physicians to fully monitor hospital patients remotely.
9 (b) The commission shall adopt and implement policies that
10 encourage the use of electronic transactions in Medicaid. The
11 policies must:
12 (1) promote electronic payment systems for Medicaid
13 providers, including electronic funds transfer or other electronic
14 payment remittance and electronic payment status reports; and
15 (2) encourage providers through the use of incentives
16 to submit claims and prior authorization requests electronically to
17 help promote faster response times and reduce the administrative
18 costs related to paper claims processing.
19 SECTION 7. Section 531.0317, Government Code, is amended by
20 adding Subsections (c-1) and (c-2) to read as follows:
21 (c-1) For the portion of the Internet site relating to
22 Medicaid, the commission shall:
23 (1) ensure the information is accessible and usable;
24 (2) publish Medicaid managed care organization
25 performance measures; and
26 (3) organize and maintain that portion of the Internet
27 site in a manner that serves Medicaid recipients, providers, and

managed care organizations, stakeholders, and the public.

(c-2) The commission shall establish and maintain an interactive, public portal on the Internet site that incorporates data collected under Section 533.026 to allow Medicaid recipients to compare Medicaid managed care organizations within a service region.

SECTION 8. Section 531.073, Government Code, is amended by adding Subsection (k) to read as follows:

(k) The commission annually shall review prior authorization requirements in the Medicaid vendor drug program and determine whether to change, update, or delete any of the requirements.

SECTION 9. Section 531.076, Government Code, is amended by amending Subsection (b) and adding Subsections (c), (d), (e), (f), (g), and (h) to read as follows:

(b) The commission shall monitor Medicaid managed care organizations to ensure that the organizations:

(1) are using prior authorization and utilization review processes to reduce authorizations of unnecessary services and inappropriate use of services; and

(2) are not using prior authorization to negatively impact recipients' access to care.

(c) The commission annually shall review a Medicaid managed care organization's prior authorization requirements and determine whether the organization should change, update, or delete any of those requirements.

(d) To enable the commission to increase the commission's

1 utilization review resources with respect to Medicaid managed care
2 organization performance, the commission shall:
3 (1) increase the sample size and types of services
4 subject to utilization review to ensure an adequate and
5 representative sample;
6 (2) use a data-driven approach to efficiently select
7 cases for utilization review that aligns with the commission's
8 priorities for improved outcomes; and
9 (3) use additional measures the commission considers
10 appropriate.
11 (e) The commission shall request information regarding and
12 review the outcomes and timeliness of a Medicaid managed care
13 organization's prior authorizations to determine for particular
14 service requests:
15 (1) the number of service hours and units requested,
16 delivered, and billed;
17 (2) the period the prior authorization request was
18 pending;
19 (3) whether the organization denied, approved, or
20 amended the prior authorization request; and
21 (4) whether a denied prior authorization request
22 resulted in an internal appeal or an appeal to the third-party
23 arbiter described by Section 533.00715.
24 (f) The commission may:
25 (1) require an assessment of a Medicaid managed care
26 organization's employee who conducts utilization review to ensure
27 the employee's decisions and assessments are consistent with those

of other employees, clinical criteria, and guidelines;

(2) require the organization to provide a sample case to:

(A) test how the organization conducts service planning and utilization review; and

(B) determine whether the organization is following the organization's utilization management policies and procedures as expressed in the contract between the organization and the commission, the organization's patient handbook, and other publicly available written documents; and

(3) randomly select an employee to test how the organization conducts service planning and utilization review, particularly in the:

(A) STAR+PLUS Medicaid managed care program;

(B) STAR Kids managed care program; and

(C) STAR Health program.

(g) To the extent feasible, the commission shall align treatments and conditions subject to prior authorization to create uniformity among Medicaid managed care plans. The commission by rule shall require each Medicaid managed care organization to submit to the commission at least every two years a list of the conditions and treatments subject to prior authorization under the managed care plan offered by the organization. The commission shall designate a single, searchable, public-facing Internet website that contains prior authorization lists categorized by Medicaid managed care program and subcategorized by Medicaid managed care organization.

(h) The commission's and each Medicaid managed care organization's prior authorization requirements, including prior authorization requirements applicable in the Medicaid vendor drug program, must be based on publicly available clinical criteria and posted in an easily searchable format on their respective Internet websites. Information posted under this subsection must include the date of last review.

SECTION 10. Section 533.00253, Government Code, is amended by adding Subsections (f) and (g) to read as follows:

(f) The commission shall ensure that the care coordinator for a Medicaid managed care organization under the STAR Kids managed care program offers a recipient's parent or legally authorized representative the opportunity to review and comment on the recipient's completed care needs assessment before the assessment is used to determine the services to be provided to the recipient. The commission shall require the parent's or representative's electronic signature to verify the parent or representative received the opportunity to review and comment on the assessment and indicate whether the parent or representative agrees with the assessment or disagrees and wishes to dispute the assessment based on medical necessity. The commission shall provide a parent or representative who disagrees with a care needs assessment an opportunity to dispute the assessment with the commission.

(g) The commission, in consultation with stakeholders, shall redesign the care needs assessment used in the STAR Kids managed care program to ensure the assessment collects useable data

pertinent to a child's physical, behavioral, and long-term care needs. This subsection expires September 1, 2021.

SECTION 11. Subchapter A, Chapter 533, Government Code, is amended by adding Sections 533.002533 and 533.00271 to read as follows:

Sec. 533.002533. CONTINUATION OF STAR KIDS MANAGED CARE ADVISORY COMMITTEE. The commission shall periodically evaluate whether to continue the STAR Kids Managed Care Advisory Committee established under former Section 533.00254 as a forum to identify and make recommendations for resolving eligibility, clinical, and administrative issues with the STAR Kids managed care program.

Sec. 533.00271. EXTERNAL QUALITY REVIEW ORGANIZATION: EVALUATION OF MEDICAID MANAGED CARE GENERALLY. (a) The commission annually shall identify and study areas of Medicaid managed care organization services for which the commission needs additional information. The external quality review organization annually shall study and report to the commission on at least three measures related to the identified areas and included in the core set of children's health care quality measures or core set of adults' health care quality measures published by the United States Department of Health and Human Services.

(b) The external quality review organization annually shall:

(1) compare private health plans, including not-for-profit community health plans and for-profit health plans, and managed care plans offered through contracts under this chapter; and

1 (2) report to the commission the comparison between
2 those plans on the following under the plans:
3 (A) rates of:
4 (i) inquiries about services and benefits;
5 (ii) inquiries and complaints about access
6 to a provider in an enrollee's local area;
7 (iii) formal complaints; and
8 (iv) service denials;
9 (B) outcomes of internal appeals, including the
10 number of appeals reversed;
11 (C) outcomes of fair hearing requests, if
12 applicable;
13 (D) constituent complaints brought to the health
14 plan's or Medicaid managed care organization's attention by an
15 individual or entity, including a state legislator or the
16 commission; and
17 (E) data disaggregated by the individual or
18 entity that initiated an inquiry or complaint.
19 (c) The commission shall require each Medicaid managed care
20 organization to submit monthly the information described by
21 Subsection (b).
22 SECTION 12. Section 533.005, Government Code, is amended by
23 amending Subsection (a) and adding Subsection (g) to read as
24 follows:
25 (a) A contract between a managed care organization and the
26 commission for the organization to provide health care services to
27 recipients must contain:

(1) procedures to ensure accountability to the state for the provision of health care services, including procedures for financial reporting, quality assurance, utilization review, and assurance of contract and subcontract compliance;

(2) capitation rates that ensure the cost-effective provision of quality health care;

(3) a requirement that the managed care organization provide ready access to a person who assists recipients in resolving issues relating to enrollment, plan administration, education and training, access to services, and grievance procedures;

(4) a requirement that the managed care organization provide ready access to a person who assists providers in resolving issues relating to payment, plan administration, education and training, and grievance procedures;

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

(6) procedures for recipient outreach and education;

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

(A) not later than:

(i) the 10th day after the date the claim is

received if the claim relates to services provided by a nursing facility, intermediate care facility, or group home;

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

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

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

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

<u>(7-b) a requirement that the managed care organization pay liquidated damages for each failure, as determined by the commission, to comply with Subdivision (7) in an amount that is a reasonable forecast of the damages caused by the noncompliance;</u>

(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

1 provide the information required by Section 533.012 and otherwise
2 comply and cooperate with the commission's office of inspector
3 general and the office of the attorney general;
4 (11) a requirement that the managed care
5 organization's usages of out-of-network providers or groups of
6 out-of-network providers may not exceed limits for those usages
7 relating to total inpatient admissions, total outpatient services,
8 and emergency room admissions determined by the commission;
9 (12) if the commission finds that a managed care
10 organization has violated Subdivision (11), a requirement that the
11 managed care organization reimburse an out-of-network provider for
12 health care services at a rate that is equal to the allowable rate
13 for those services, as determined under Sections 32.028 and
14 32.0281, Human Resources Code;
15 (13) a requirement that, notwithstanding any other
16 law, including Sections 843.312 and 1301.052, Insurance Code, the
17 organization:
18 (A) use advanced practice registered nurses and
19 physician assistants in addition to physicians as primary care
20 providers to increase the availability of primary care providers in
21 the organization's provider network; and
22 (B) treat advanced practice registered nurses
23 and physician assistants in the same manner as primary care
24 physicians with regard to:
25 (i) selection and assignment as primary
26 care providers;
27 (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 comply with the recipient appeals procedure established under Section 533.00715 and develop, implement, and maintain a system for tracking and resolving all provider appeals related to claims payment, including a process that will require:

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

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

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

(D) the managed care organization to allow a

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

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

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

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

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

(20) a requirement that the managed care organization:

(A) develop and submit to the commission, before the organization begins to provide health care services to recipients, a comprehensive plan that describes how the organization's provider network complies with the provider access standards established under Section 533.0061;

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

(i) continue to comply with the provider

access standards established under Section 533.0061; 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;

(C) pay liquidated damages for each failure, as determined by the commission, to comply with the provider access standards established under Section 533.0061 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-1) [~~533.0061(a)~~] and specific data with respect to access to primary care, specialty care, long-term services and supports, nursing services, and therapy services on 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 date the organization approves a request for prior authorization for the care or service and the date the care or service is initiated;

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

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 and the core sets of children's and adults'

health care quality measures published by the United States Department of Health and Human Services;

(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;

1 (F) under which the managed care organization may
2 not prohibit, limit, or interfere with a recipient's selection of a
3 pharmacy or pharmacist of the recipient's choice for the provision
4 of pharmaceutical services under the plan through the imposition of
5 different copayments;
6 (G) that allows the managed care organization or
7 any subcontracted pharmacy benefit manager to contract with a
8 pharmacist or pharmacy providers separately for specialty pharmacy
9 services, except that:
10 (i) the managed care organization and
11 pharmacy benefit manager are prohibited from allowing exclusive
12 contracts with a specialty pharmacy owned wholly or partly by the
13 pharmacy benefit manager responsible for the administration of the
14 pharmacy benefit program; and
15 (ii) the managed care organization and
16 pharmacy benefit manager must adopt policies and procedures for
17 reclassifying prescription drugs from retail to specialty drugs,
18 and those policies and procedures must be consistent with rules
19 adopted by the executive commissioner and include notice to network
20 pharmacy providers from the managed care organization;
21 (H) under which the managed care organization may
22 not prevent a pharmacy or pharmacist from participating as a
23 provider if the pharmacy or pharmacist agrees to comply with the
24 financial terms and conditions of the contract as well as other
25 reasonable administrative and professional terms and conditions of
26 the contract;
27 (I) under which the managed care organization may

1 include mail-order pharmacies in its networks, but may not require
2 enrolled recipients to use those pharmacies, and may not charge an
3 enrolled recipient who opts to use this service a fee, including
4 postage and handling fees;
5 (J) under which the managed care organization or
6 pharmacy benefit manager, as applicable, must pay claims in
7 accordance with Section 843.339, Insurance Code; 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

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:

(A) subject to Subsection (a-3), the organization has the prior approval of the commission to make the <u>reductions</u> [~~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

1 make initial and subsequent primary care provider assignments and
2 changes;
3 (27) a requirement that the managed care organization
4 pend a prior authorization request or claim awaiting a peer-to-peer
5 review;
6 (28) a requirement that the managed care organization:
7 (A) timely respond to prior authorization
8 requests;
9 (B) not deny a reasonable prior authorization
10 request or claim for a technical or minimal error;
11 (C) not abuse the appeals process to deter a
12 recipient or provider from requesting health care services; and
13 (D) pay liquidated damages for each failure, as
14 determined by the commission, to comply with this subdivision in an
15 amount that is a reasonable forecast of the damages caused by the
16 noncompliance;
17 (29) a requirement that the managed care organization:
18 (A) automatically, without a request from a
19 recipient or program, continue to provide the pre-reduction or
20 pre-denial level of services to the recipient during an internal
21 appeal or an appeal to the third-party arbiter described by Section
22 533.00715 of a reduction in or denial of services, unless the
23 recipient or the recipient's parent on behalf of the recipient opts
24 out of the automatic continuation of services;
25 (B) provide the commission and the recipient with
26 a notice of continuing services, receipt of which is verified by
27 electronic signature or through other electronic means; and

(C) pay liquidated damages for each failure, as determined by the commission, to comply with this subdivision in an amount that is a reasonable forecast of the damages caused by the noncompliance; and

(30) a requirement that the managed care organization, after a prior authorization denial or adverse benefit determination, provide a recipient with a letter that includes a thorough and detailed explanation for the prior authorization denial or adverse determination.

(g) The commission shall provide guidance and additional education to managed care organizations regarding requirements under federal law and Subsection (a)(29) to continue to provide services during an internal appeal and a Medicaid fair hearing.

SECTION 13. Section 533.0051, Government Code, is amended by adding Subsection (h) to read as follows:

(h) To monitor performance measures, the commission shall develop a data-sharing platform that enables divisions within the commission to electronically view data and access data analysis in a single location.

SECTION 14. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0058 to read as follows:

Sec. 533.0058. STAR HEALTH PROGRAM: INITIAL THERAPY EVALUATION. A Medicaid managed care organization that provides health care services under the STAR Health program may not require prior authorization for an initial therapy evaluation for a recipient.

SECTION 15. The heading to Section 533.0061, Government

1 Code, is amended to read as follows:
2 Sec. 533.0061. PROVIDER ACCESS STANDARDS AND NETWORK
3 ADEQUACY; REPORT.
4 SECTION 16. Section 533.0061, Government Code, is amended
5 by amending Subsection (a) and adding Subsections (a-1), (b-1),
6 (b-2), (b-3), (b-4), (d), and (e) to read as follows:
7 (a) In this section:
8 (1) "Access to care" means access to care and services
9 available under Medicaid at least to the same extent that similar
10 care and services are available to the general population in the
11 recipient's geographic area.
12 (2) "Network adequacy" means the adequacy of a
13 Medicaid managed care organization's provider network determined
14 according to standards established by federal law.
15 (a-1) The commission shall establish minimum provider
16 access standards for the provider network of a managed care
17 organization that contracts with the commission to provide health
18 care services to recipients. The access standards must ensure that
19 a Medicaid managed care organization provides recipients
20 sufficient access to:
21 (1) preventive care;
22 (2) primary care;
23 (3) specialty care;
24 (4) after-hours urgent care;
25 (5) chronic care;
26 (6) long-term services and supports;
27 (7) nursing services;

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

(9) any other services identified by the commission.

(b-1) Except as provided by Subsection (b-4), the commission shall use travel time and distance standards to measure network adequacy.

(b-2) In determining network adequacy, the commission shall use automated data validation and calculation tools to decrease processing time and resources required for calculating provider distance and travel time.

(b-3) The commission shall integrate access to care data with network adequacy data to evaluate and monitor provider network adequacy based on both provider location and availability.

(b-4) To account for differences in recipient population and provider entity size, the commission shall establish provider network adequacy standards, other than travel time and distance standards, applicable in assessing the network adequacy for personal care attendants and providers of long-term services and supports who travel to a recipient to provide care. The external quality review organization shall periodically evaluate and report to the commission on personal care attendant network adequacy.

(d) The executive commissioner by rule shall ensure that an evaluation of a Medicaid managed care organization's provider network adequacy conducted by the commission or the external quality review organization with information obtained from a managed care organization's provider network directory is based on the total number of providers listed in the directory. The

1 commission or external quality review organization must consider a
2 provider with incorrect contact information or who is no longer
3 participating in Medicaid as having no appointment availability for
4 purposes of the evaluation.
5 (e) The external quality review organization shall use
6 existing encounter data to monitor a Medicaid managed care
7 organization's network adequacy and the accuracy of the
8 organization's provider directories.
9 SECTION 17. Section 533.0063, Government Code, is amended
10 by adding Subsection (d) to read as follows:
11 (d) The commission shall use the commission's master file of
12 Medicaid providers to validate the provider network directory of a
13 managed care organization described by Subsection (a).
14 SECTION 18. Section 533.0071, Government Code, is amended
15 to read as follows:
16 Sec. 533.0071. ADMINISTRATION OF CONTRACTS. (a) The
17 commission shall make every effort to improve the administration of
18 contracts with Medicaid managed care organizations. To improve the
19 administration of these contracts, the commission shall:
20 (1) ensure that the commission has appropriate
21 expertise and qualified staff to effectively manage contracts with
22 managed care organizations under the Medicaid managed care program;
23 (2) evaluate options for Medicaid payment recovery
24 from managed care organizations if the enrollee dies or is
25 incarcerated or if an enrollee is enrolled in more than one state
26 program or is covered by another liable third party insurer;
27 (3) maximize Medicaid payment recovery options by

1 contracting with private vendors to assist in the recovery of
2 capitation payments, payments from other liable third parties, and
3 other payments made to managed care organizations with respect to
4 enrollees who leave the managed care program; and
5 (4) decrease the administrative burdens of managed
6 care for the state, the managed care organizations, and the
7 providers under managed care networks to the extent that those
8 changes are compatible with state law and existing Medicaid managed
9 care contracts, including decreasing those burdens by:
10 (A) where possible, decreasing the duplication
11 of administrative reporting and process requirements for the
12 managed care organizations and providers, such as requirements for
13 the submission of encounter data, quality reports, historically
14 underutilized business reports, and claims payment summary
15 reports;
16 (B) allowing managed care organizations to
17 provide updated address information directly to the commission for
18 correction in the state system;
19 (C) promoting consistency and uniformity among
20 managed care organization policies, including policies relating to
21 the preauthorization process, lengths of hospital stays, filing
22 deadlines, levels of care, and case management services;
23 (D) reviewing the appropriateness of primary
24 care case management requirements in the admission and clinical
25 criteria process, such as requirements relating to including a
26 separate cover sheet for all communications, submitting
27 handwritten communications instead of electronic or typed review

processes, and admitting patients listed on separate notifications; and

(E) providing a portal 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~~].

(b) For a contract described by Subsection (a), the commission shall:

(1) automate the process for receiving and tracking contract amendment requests and incorporating an amendment into a contract;

(2) make the most recent contract amendment information readily available among divisions within the commission; and

(3) provide technical assistance and education to help a commission employee determine whether a requested contract amendment is necessary or whether the issue could be resolved through the uniform managed care manual, a memorandum, or guidance.

(c) The commission shall create a summary compliance framework that summarizes contract provisions to help Medicaid managed care organizations comply with those provisions.

(d) The commission shall annually review and assess contract deliverables and eliminate unnecessary deliverables for

Medicaid managed care contracts. The commission may identify measures to strengthen the contract deliverables and implement those measures as needed.

SECTION 19. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00715 to read as follows:

Sec. 533.00715. INDEPENDENT APPEALS PROCEDURE. (a) In this section, "third-party arbiter" means a third-party medical review organization that provides objective, unbiased medical necessity determinations conducted by clinical staff with education and practice in the same or similar practice area as the procedure for which an independent determination of medical necessity is sought.

(b) The commission shall contract with an independent, third-party arbiter to resolve recipient appeals related to a reduction in or denial of health care services on the basis of medical necessity in the Medicaid managed care program.

(c) The arbiter shall establish a common procedure for appeals. The procedure must provide that a health care service ordered by a health care provider is presumed medically necessary and the Medicaid managed care organization bears the burden of proof to show the health care service is not medically necessary. The arbiter shall also establish a procedure for expedited appeals that allows the arbiter to:

(1) identify an appeal that requires an expedited resolution; and

(2) resolve the appeal within a specified period.

(d) The arbiter shall establish and maintain an Internet

portal through which a recipient may track the status and final disposition of an appeal.

(e) The arbiter shall educate recipients and employees of Medicaid managed care organizations regarding appeals processes, options, and proper and improper denials of health care services on the basis of medical necessity.

(f) The third-party arbiter shall review aggregate denial data categorized by Medicaid managed care plan to identify trends and determine whether a Medicaid managed care organization is disproportionately denying prior authorization requests from a single provider or set of providers.

SECTION 20. The heading to Section 533.0072, Government Code, is amended to read as follows:

Sec. 533.0072. CORRECTIVE ACTION PLANS AND [~~INTERNET POSTING OF~~] SANCTIONS IMPOSED FOR CONTRACTUAL VIOLATIONS.

SECTION 21. Section 533.0072, Government Code, is amended by amending Subsections (a), (b), and (c) and adding Subsections (b-1) and (b-2) to read as follows:

(a) The commission shall prepare and maintain a record of each enforcement action initiated by the commission [~~that results in a sanction, including a penalty, being imposed~~] against a managed care organization for failure to comply with the terms of a contract to provide health care services to recipients through a managed care plan issued by the organization, including:

(1) an enforcement action that results in a sanction, including a penalty;

(2) the imposition of a corrective action plan;

(3) the imposition of liquidated damages;

(4) the suspension of default enrollment; and

(5) the termination of the organization's contract.

(b) The record must include:

(1) the name and address of the organization;

(2) a description of the contractual obligation the organization failed to meet;

(3) the date of determination of noncompliance;

(4) the date the sanction was imposed, if applicable;

(5) the maximum sanction that may be imposed under the contract for the violation, if applicable; and

(6) the actual sanction imposed against the organization, if applicable.

(b-1) In assessing liquidated damages against a Medicaid managed care organization, the commission shall:

(1) include in the record prepared under Subsection (a):

(A) each step taken in the process of recommending and assessing liquidated damages; and

(B) the reason for any reduction of liquidated damages from the recommended amount;

(2) assess liquidated damages in an amount that is sufficient to ensure compliance with the uniform managed care contract and is a reasonable forecast of the damages caused by the noncompliance; and

(3) apply liquidated damages and other enforcement actions consistently among Medicaid managed care organizations for

similar violations.

(b-2) If the commission reduces the sanction or penalty in an enforcement action, the commission shall include in the record prepared under Subsection (a) the reason for the reduction.

(c) The commission shall post and maintain the records required by this section on the commission's Internet website in English and Spanish. The commission's office of inspector general shall post and maintain the records relating to corrective action plans required by this section on the office's Internet website. The records must be posted in a format that is readily accessible to and understandable by a member of the public. The commission and the office shall update the list of records on the website at least quarterly.

SECTION 22. Section 533.0075, Government Code, is amended to read as follows:

Sec. 533.0075. RECIPIENT ENROLLMENT. (a) The commission shall:

(1) encourage recipients to choose appropriate managed care plans and primary health care providers by:

(A) providing initial information to recipients and providers in a region about the need for recipients to choose plans and providers not later than the 90th day before the date on which a managed care organization plans to begin to provide health care services to recipients in that region through managed care;

(B) providing follow-up information before assignment of plans and providers and after assignment, if necessary, to recipients who delay in choosing plans and providers;

and

(C) allowing plans and providers to provide information to recipients or engage in marketing activities under marketing guidelines established by the commission under Section 533.008 after the commission approves the information or activities;

(2) consider the following factors in assigning managed care plans and primary health care providers to recipients who fail to choose plans and providers:

(A) the importance of maintaining existing provider-patient and physician-patient relationships, including relationships with specialists, public health clinics, and community health centers;

(B) to the extent possible, the need to assign family members to the same providers and plans; [~~and~~]

(C) geographic convenience of plans and providers for recipients;

(D) a recipient's previous plan assignment;

(E) the Medicaid managed care organization's performance on quality assurance and improvement;

(F) enforcement actions, including liquidated damages, imposed against the managed care organization;

(G) corrective action plans the commission has required the managed care organization to implement; and

(H) other reasonable factors that support the objectives of the managed care program;

(3) retain responsibility for enrollment and

disenrollment of recipients in managed care plans, except that the commission may delegate the responsibility to an independent contractor who receives no form of payment from, and has no financial ties to, any managed care organization;

(4) develop and implement an expedited process for determining eligibility for and enrolling pregnant women and newborn infants in managed care plans; and

(5) ensure immediate access to prenatal services and newborn care for pregnant women and newborn infants enrolled in managed care plans, including ensuring that a pregnant woman may obtain an appointment with an obstetrical care provider for an initial maternity evaluation not later than the 30th day after the date the woman applies for Medicaid.

(b) To help new recipients easily compare managed care plans with regard to quality and patient satisfaction measures, the commission shall incorporate information the commission determines is relevant in Medicaid managed care report cards, including:

(1) feedback from recipient complaints;

(2) a Medicaid managed care organization's rate of denials and appeals;

(3) outcomes of internal appeals; and

(4) information for each organization related to independent appeals under Section 533.00715.

(c) After enrolling a recipient in the medically dependent children (MDCP) waiver program or the STAR+PLUS Medicaid managed care program, the commission shall require the recipient's or legally authorized representative's electronic signature to verify

1 the recipient received the recipient handbook.

2 (d) The commission shall:

3 (1) survey a select sample of recipients receiving
4 benefits under the medically dependent children (MDCP) waiver
5 program or the STAR+PLUS Medicaid managed care program to determine
6 whether the recipients:

7 (A) received the recipient handbook required by
8 contract to be provided within the required period; and

9 (B) understand the information in the recipient
10 handbook; and

11 (2) provide a sample recipient handbook to Medicaid
12 managed care organizations.

13 SECTION 23. Subchapter A, Chapter 533, Government Code, is
14 amended by adding Section 533.0095 to read as follows:

15 Sec. 533.0095. CERTAIN PRIOR AUTHORIZATION EXTENSIONS. (a)
16 The commission shall establish a list of health care services and
17 prescription drugs for which a Medicaid managed care organization
18 must grant extended prior authorization periods or amounts, as
19 applicable, without requiring additional proof or documentation.
20 The commission shall also establish a list of chronic health and
21 mental health conditions the treatments for which a Medicaid
22 managed care organization must grant extended prior authorization
23 periods without requiring additional proof or documentation. The
24 commission shall establish the extended periods and amounts.

25 (b) The commission shall establish the lists in
26 consultation with stakeholders, including physicians, hospitals,
27 patient advocacy groups, and Medicaid managed care organizations.

1 The commission shall consult with stakeholders through the Medicaid
2 managed care advisory committee.
3 (c) The commission's medical director shall solicit and
4 receive provider feedback regarding extended prior authorization
5 periods, including feedback related to which health care services,
6 prescription drugs, and health and mental health conditions should
7 be subject to extended prior authorization periods.
8 (d) The commission shall update the lists semiannually with
9 input from the medical care advisory committee established under
10 Section 32.022, Human Resources Code.
11 SECTION 24. The heading to Section 533.015, Government
12 Code, is amended to read as follows:
13 Sec. 533.015. [~~COORDINATION OF~~] EXTERNAL OVERSIGHT
14 ACTIVITIES.
15 SECTION 25. Section 533.015, Government Code, is amended by
16 adding Subsection (d) to read as follows:
17 (d) In overseeing Medicaid managed care organizations, the
18 commission's office of inspector general shall use a program
19 integrity methodology appropriate for managed care. The office may
20 explore different options to measure program integrity efforts,
21 including:
22 (1) quantifying and validating cost avoidance in a
23 managed care context; and
24 (2) adapting existing program integrity tools to
25 address specific risks and incentives related to risk-based and
26 value-based arrangements.
27 SECTION 26. Subchapter A, Chapter 533, Government Code, is

1 amended by adding Sections 533.026, 533.027, 533.028, and 533.031
2 to read as follows:
3 Sec. 533.026. ENHANCED DATA COLLECTION AND REPORTING OF
4 ADMINISTRATIVE COSTS; CONTRACT OVERSIGHT. (a) The commission
5 shall collect accurate, consistent, and verifiable data from
6 Medicaid managed care organizations, including line-item data for
7 administrative costs.
8 (b) The commission shall use data collected from a Medicaid
9 managed care organization under this section to:
10 (1) identify grievances, as defined by Section
11 533.027;
12 (2) monitor contract compliance;
13 (3) identify other programmatic issues; and
14 (4) identify whether the organization is:
15 (A) unnecessarily denying, reducing, or
16 otherwise failing to provide health care services to recipients;
17 (B) delaying or denying provider claims due to
18 technical or minimal errors; or
19 (C) otherwise engaging in behavior that merits an
20 enforcement action.
21 (c) A Medicaid managed care organization shall report
22 administrative costs in the organization's financial statistical
23 report and shall report those costs to the commission at least
24 annually. The commission shall report information provided under
25 this subsection annually to the lieutenant governor, the speaker of
26 the house, and each standing committee of the legislature with
27 jurisdiction over financing, operating, and overseeing Medicaid.

1 (d) The commission shall use data from grievances collected
2 under Section 533.027 for contract oversight and to determine
3 contract risk.
4 (e) The commission shall:
5 (1) provide financial subject matter expertise for
6 Medicaid managed care contract review and compliance oversight
7 among divisions within the commission;
8 (2) conduct extensive validation of Medicaid managed
9 care financial data; and
10 (3) analyze the ultimate underlying cause of an issue
11 to resolve that cause and prevent similar issues from arising in the
12 future within Medicaid managed care.
13 (f) The commission's office of inspector general shall
14 assist the commission in implementing this section.
15 Sec. 533.027. MANAGED CARE GRIEVANCES: PROCESSES AND
16 TRACKING. (a) In this section, "grievance" includes an inquiry
17 about services or benefits, an inquiry or complaint about access to
18 a provider in a recipient's local area, a formal complaint, a
19 request for internal appeal, a request for a fair hearing, and a
20 complaint brought by an individual or entity, including a
21 legislator or the commission, submitted to or received by:
22 (1) a commission employee;
23 (2) a Medicaid managed care organization;
24 (3) the commission's office of inspector general;
25 (4) the commission's office of the ombudsman;
26 (5) the office of ombudsman for Medicaid providers; or
27 (6) the Department of Family and Protective Services.

1 (b) The commission shall:
2 (1) provide education and training to commission
3 employees on the correct issue resolution processes for Medicaid
4 managed care grievances; and
5 (2) require those employees to promptly report
6 grievances into the commission's grievance tracking system to
7 enable employees to track and timely resolve grievances.
8 (c) To ensure all grievances are managed consistently, the
9 commission shall ensure the definition of a grievance is consistent
10 among:
11 (1) commission employees and divisions within the
12 commission;
13 (2) Medicaid managed care organizations;
14 (3) the commission's office of inspector general;
15 (4) the commission's office of the ombudsman;
16 (5) the office of ombudsman for Medicaid providers;
17 and
18 (6) the Department of Family and Protective Services.
19 (d) The commission shall enhance the Medicaid managed care
20 grievance-tracking system's reporting capabilities and standardize
21 data reporting among divisions within the commission.
22 (e) In coordination with the executive commissioner's
23 duties under Section 531.0171, the commission shall implement a
24 no-wrong-door system for Medicaid managed care grievances reported
25 to the commission. The commission shall ensure that commission
26 employees, Medicaid managed care organizations, the commission's
27 office of inspector general, the commission's office of the

ombudsman, the office of ombudsman for Medicaid providers, and the Department of Family and Protective Services use common practices and policies and provide consistent resolutions for Medicaid managed care grievances.

(f) The commission in conjunction with the commission's office of inspector general shall:

(1) implement a data analytics program to aggregate rates of inquiries, complaints, calls, denials, and fair hearing requests; and

(2) include the aggregate rating and data analysis in each Medicaid managed care organization's quality rating.

Sec. 533.028. CARE COORDINATION AND CARE COORDINATORS. (a) In this section, "care coordination" means assisting recipients to develop a plan of care, including a service plan, that meets the recipient's needs and coordinating the provision of Medicaid benefits in a manner that is consistent with the plan of care. The term is synonymous with "case management," "service coordination," and "service management."

(b) The commission shall ensure a person, including a case manager, who is engaged by a Medicaid managed care organization to provide care coordination benefits is consistently referred to as a "care coordinator" throughout divisions within the commission and across all Medicaid programs and services for recipients receiving benefits under a managed care delivery model.

(c) The commission shall expeditiously develop materials explaining the role of care coordinators by Medicaid managed care product line. The commission shall establish clear expectations

1 that the care coordinator communicate with a recipient's health
2 care providers with the goal of ensuring coordinated, effective,
3 and efficient care delivery.
4 (d) The commission shall collect data on care coordination
5 touchpoints with recipients.
6 (e) The commission shall provide to each Medicaid managed
7 care organization information regarding best practices for care
8 coordination services for the organization to incorporate into
9 providing care.
10 (f) The commission shall require a Medicaid managed care
11 organization to offer a provider in the organization's provider
12 network the option to have an organization's care coordinator
13 on-site at the provider's practice. The commission shall ensure a
14 care coordinator is reimbursed for care coordination services
15 provided on-site and encourage managed care organizations to place
16 care coordinators on-site.
17 (g) In this subsection, "potentially preventable admission"
18 and "potentially preventable readmission" have the meanings
19 assigned by Section 536.001. The commission shall change the
20 methodology for calculating potentially preventable admissions and
21 potentially preventable readmissions to exclude from those
22 admission and readmission rates hospitalizations in which a
23 Medicaid managed care organization did not adequately coordinate
24 the patient's care. The methodology must apply to physical and
25 behavioral health conditions.
26 (h) The executive commissioner shall include a provision
27 establishing key performance metrics for care coordination in a

1 contract between a managed care organization and the commission for
2 the organization to provide health care services to recipients
3 receiving home and community-based services under the:
4 (1) STAR+PLUS Medicaid managed care program;
5 (2) STAR Kids managed care program; or
6 (3) STAR Health program.
7 (i) The commission shall establish for Medicaid managed
8 care organizations and ensure compliance with metrics for the
9 following:
10 (1) a dedicated toll-free care coordination telephone
11 number;
12 (2) the time frame for the return of telephone calls;
13 (3) notice of the name and telephone number of a
14 recipient's care coordinator;
15 (4) notice of changes in the name or telephone number
16 of a recipient's care coordinator;
17 (5) initiation of assessments and reassessments;
18 (6) establishment and regular updating of
19 comprehensive, person-centered individual service plans; and
20 (7) number of face-to-face and telephonic contacts for
21 each care coordination level.
22 Sec. 533.031. COORDINATION OF BENEFITS UNDER MEDICALLY
23 DEPENDENT CHILDREN (MDCP) WAIVER PROGRAM. The commission shall
24 prohibit a Medicaid managed care organization providing health care
25 services under the medically dependent children (MDCP) waiver
26 program from requiring additional authorization from an enrolled
27 child's health care provider for a service if the child's third

1 party health benefit plan issuer authorizes the service.
2 SECTION 27. Section 536.007, Government Code, is amended by
3 adding Subsection (b) to read as follows:
4 (b) The commission's medical director is responsible for
5 convening periodic meetings with Medicaid health care providers,
6 including hospitals, to analyze and evaluate all Medicaid managed
7 care and health care provider quality-based programs to ensure
8 feasibility and alignment among programs.
9 SECTION 28. As soon as practicable after the effective date
10 of this Act, the Health and Human Services Commission shall
11 implement the changes in law made by this Act.
12 SECTION 29. Section 533.005, Government Code, as amended by
13 this Act, applies only to a contract entered into or renewed on or
14 after the effective date of this Act. A contract entered into or
15 renewed before that date is governed by the law in effect on the
16 date the contract was entered into or renewed, and that law is
17 continued in effect for that purpose.
18 SECTION 30. If before implementing any provision of this
19 Act a state agency determines that a waiver or authorization from a
20 federal agency is necessary for implementation of that provision,
21 the agency affected by the provision shall request the waiver or
22 authorization and may delay implementing that provision until the
23 waiver or authorization is granted.
24 SECTION 31. If any provision of this Act or its application
25 to any person or circumstance is held invalid, the invalidity does
26 not affect other provisions or applications of this Act that can be
27 given effect without the invalid provision or application, and to

1 this end the provisions of this Act are declared to be severable.

2 SECTION 32. This Act takes effect September 1, 2019.