By: Hinojosa S.B. No. 2082

A BILL TO BE ENTITLED

AN ACT

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

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

SECTION 1. Subchapter C, Chapter 531, Government Code, is amended by adding Section 531.1133 to read as follows:

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

(b) This section does not:

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

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

SECTION 2. Section 533.005, Government Code, is amended by

amending Subsection (a) and adding Subsection (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 offered by the managed care organization on any claim for payment that is received with documentation reasonably necessary for the managed care organization to process the claim:

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

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

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

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

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

(7-a) a requirement that the managed care organization demonstrate to the commission that the organization pays claims to which [~~described by~~] Subdivision (7)(B) applies [~~(7)(A)(ii)~~] on average not later than the 15th [~~21st~~] day after the date the claim is received by the organization;

(7-b) a requirement that the managed care organization demonstrate to the commission that, within each provider category and service delivery area designated by the commission, the

organization pays at least 98 percent of claims within the times prescribed by Subdivision (7);

(7-c) a requirement that the managed care organization establish an electronic process for use by providers in submitting claims documentation that complies with Section 533.0055(b)(6) and allows providers to submit additional documentation on a claim when the organization determines the claim was not submitted with documentation reasonably necessary to process the claim;

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

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

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

(11) a requirement that the managed care organization's utilization [~~usages~~] of out-of-network providers or groups of out-of-network providers may not exceed limits determined by the commission, including limits [~~for those usages~~] relating to:

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

(B) acute care services not described by

1 Paragraph (A); and
2 (C) long-term services and supports;
3 (12) if the commission finds that a managed care
4 organization has violated Subdivision (11), a requirement that the
5 managed care organization reimburse an out-of-network provider for
6 health care services at a rate that is equal to the allowable rate
7 for those services, as determined under Sections 32.028 and
8 32.0281, Human Resources Code;
9 (13) a requirement that, notwithstanding any other
10 law, including Sections 843.312 and 1301.052, Insurance Code, the
11 organization:
12 (A) use advanced practice registered nurses and
13 physician assistants in addition to physicians as primary care
14 providers to increase the availability of primary care providers in
15 the organization's provider network; and
16 (B) treat advanced practice registered nurses
17 and physician assistants in the same manner as primary care
18 physicians with regard to:
19 (i) selection and assignment as primary
20 care providers;
21 (ii) inclusion as primary care providers in
22 the organization's provider network; and
23 (iii) inclusion as primary care providers
24 in any provider network directory maintained by the organization;
25 (14) a requirement that the managed care organization
26 reimburse a federally qualified health center or rural health
27 clinic for health care services provided to a recipient outside of

1 regular business hours, including on a weekend day or holiday, at a
2 rate that is equal to the allowable rate for those services as
3 determined under Section 32.028, Human Resources Code, if the
4 recipient does not have a referral from the recipient's primary
5 care physician;

6 (15) a requirement that the managed care organization
7 develop, implement, and maintain a system for tracking and
8 resolving all provider complaints and appeals related to claims
9 payment and prior authorization and service denials, including a
10 system [process] that will [require]:

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

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

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

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

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

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

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

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

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

(20) a requirement that the managed care organization:

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

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

(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 this [~~the~~] state from national or regional wholesalers and is not obsolete;

(ii) must provide to a network pharmacy provider, at the time a contract is entered into or renewed with the network pharmacy provider, the sources used to determine the

maximum allowable cost pricing for the maximum allowable cost list specific to that provider;

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

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

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

(vi) must:

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

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

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

appropriate;

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

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

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

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

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

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

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

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

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

(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:

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

(2) may not give preference in authorizing referrals to the provider in which the organization has an ownership interest as compared to other providers of the same or similar services participating in the organization's provider network.

SECTION 3. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.00541 to read as follows:

Sec. 533.00541. PRIOR AUTHORIZATION REQUIREMENT FOR CERTAIN POST-ACUTE CARE SERVICES BEFORE DISCHARGE.

1 Notwithstanding any other law and except as otherwise provided by a
2 settlement agreement filed with and approved by a court, the
3 commission shall require a managed care organization that contracts
4 with the commission to provide health care services to recipients
5 to, not later than 72 hours after receiving a request from a
6 provider of acute care inpatient services for prior authorization
7 for services or equipment to allow for discharge of a patient from
8 an inpatient facility, approve or pend the request.
9 SECTION 4. Subchapter A, Chapter 533, Government Code, is
10 amended by adding Section 533.00611 to read as follows:
11 Sec. 533.00611. STANDARDS FOR DETERMINING MEDICAL
12 NECESSITY. (a) Except as provided by Subsection (b), the
13 commission shall establish standards that govern the processes,
14 criteria, and guidelines under which managed care organizations
15 determine the medical necessity of a health care service covered by
16 Medicaid. In establishing standards under this section, the
17 commission shall:
18 (1) ensure that each recipient has equal access in
19 scope and duration to the same covered health care services for
20 which the recipient is eligible, regardless of the managed care
21 organization with which the recipient is enrolled;
22 (2) provide managed care organizations with
23 flexibility to approve covered medically necessary services for
24 recipients that may not be within prescribed criteria and
25 guidelines;
26 (3) require managed care organizations to make
27 available to providers all criteria and guidelines used to

determine medical necessity through an Internet portal accessible by the providers;

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

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

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

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

(2) conduct utilization reviews of those services.

SECTION 5. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0091 to read as follows:

Sec. 533.0091. CARE COORDINATION SERVICES. (a) In this section:

(1) "Care coordination" means assisting recipients to develop a plan of care, including an individual 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."

(2) "Care coordinator" means a person, including a

case manager, engaged by a managed care organization that contracts with the commission under this chapter to provide care coordination services.

(b) A managed care organization that contracts with the commission to provide health care services to recipients shall:

(1) ensure that care coordinators for the organization coordinate with hospital discharge planners, who must notify the organization of an inpatient admission of a recipient, to facilitate the timely discharge of the recipient to the appropriate level of care and minimize potentially preventable readmissions; and

(2) provide comprehensive care coordination services to adult recipients with multiple chronic conditions, including trauma-related injuries, cardiac events, and cancer.

(c) For purposes of this chapter, the commission and a managed care organization shall classify care coordination services as medical services instead of as an administrative service or expense.

SECTION 6. Subchapter A, Chapter 533, Government Code, is amended by adding Section 533.0122 to read as follows:

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

1 course of the audit.
2 (b) The commission's office of inspector general shall
3 ensure that each person conducting a utilization review audit under
4 this section has experience and training regarding the operations
5 of managed care organizations.
6 (c) The commission's office of inspector general may not, as
7 the result of a utilization review audit, recoup an overpayment or
8 debt from a provider that contracts with a managed care
9 organization based on a determination that a provided service was
10 not medically necessary unless the office:
11 (1) uses the same criteria and guidelines that were
12 used by the managed care organization in its determination of
13 medical necessity for the service; and
14 (2) verifies with the managed care organization and
15 the provider that the provider:
16 (A) at the time the service was delivered, had
17 reasonable notice of the criteria and guidelines used by the
18 managed care organization to determine medical necessity; and
19 (B) did not follow the criteria and guidelines
20 used by the managed care organization to determine medical
21 necessity that were in effect at the time the service was delivered.
22 (d) If the commission's office of inspector general
23 conducts a utilization review audit that results in a determination
24 to recoup money from a managed care organization that contracts
25 with the commission to provide health care services to recipients,
26 the provider protections from liability under Section 531.1133
27 apply.

SECTION 7. Sections 531.02176 and 533.005(a-3), Government Code, are repealed.

SECTION 8. 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 9. 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 10. This Act takes effect September 1, 2019.